

FERTILITY TRANSITION IN SOUTH AFRICA AND ITS IMPLICATIONS ON THE FOUR MAJOR POPULATION GROUPS

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A. INTRODUCTION

In general there seems to be widespread agreement that fertility began to decline among all major population groups in South Africa prior to the end of apartheid. It occurred at a much faster level for Whites and Asians as compared to Africans and Coloureds. This occurred amidst the impoverishment of millions (especially African women), stark inequalities and the disempowerment of women. Although South Africa has undergone a dramatic political transition in the last decade, many of the distortions and dynamics introduced by apartheid continue to reproduce poverty and perpetuate inequality. The South African population policy (Dept. of Welfare, 1998) argues that the basic demographic factors fertility, migration and mortality are an integral part of poverty prevalence in South Africa. These demographic factors cannot be seen in isolation from social factors such as education, unemployment, poor health and housing quality and their interrelationships with poverty. Thus, on the one hand, poverty persists, while on the other hand, fertility declines. This is in stark contrast to the experience in other parts of sub-Saharan Africa, where poverty usually goes hand in hand with high fertility. This paper investigates issues around lower fertility, factors contributing to it, its impact on the different population groups as well policies to address its impact.

1. South Africa's fertility compared to Sub-Saharan Africa

Figure I clearly illustrates that the South African fertility rate is significantly lower than that of other countries in Southern and East Africa. A steady decline in fertility in developing nations took place in the late 1980s and 1990s, especially in the regions of Asia and Latin America. In contrast, Africa and particularly sub-Saharan Africa still lag behind in fertility terms. Reasons for South Africa's low fertility compared to its neighbours is multifaceted which will be explained, later in more detail.

B. SOUTH AFRICA'S FERTILITY TRENDS

South Africa's experience in the fertility transition is among the most advanced in sub-Saharan Africa. South Africa displays demographic regimes that are typical of both developed and developing worlds. These tend to be linked to socio-economic divisions along racial and urban-rural lines. Living standards are closely correlated with race in South Africa. While poverty is not confined to any one racial group in South Africa, it is concentrated among Africans in particular. Many of the apartheid measures, including the extensive welfare system available to White people, the higher quality of education available to White students, and the formal and informal job reservations for White workers, was specifically designed in preventing poverty among the White population. As shown in figure II, poverty among Whites is close to zero. On the contrary, poverty among 'Africans', the most disadvantaged group stands at 60,7 per cent compared to 38,2 per cent, and 5,4 per cent for Coloureds and Asians. It is interesting to note, however, that the very few poor Asians and Whites also seem to be at a considerable distance below the poverty line.

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With Africans making up 77 per cent of the population, their high incidence and severity of poverty amongst them ensures that they account for 95 per cent of the poverty gap, with the remaining 3 per cent largely accounted for the poverty among Coloureds with the 1 per cent each shared by the Asians and Whites, respectively as shown in figure III.

The differences in poverty by race also contribute to the distribution of poverty by location since the racial groups were unevenly distributed in the country. At the same time, among Africans, the group comprising nearly all the country's poor, the pattern of much higher poverty in rural areas and the concentration of poverty in the former homelands and some of the provinces still holds. The fertility trends among population groups in South Africa shows the same patterns as that of poverty. The African component which is the poorest with regard to per capita income has the highest fertility rate, while the White population which has the highest per capita income has the lowest fertility rate as explained below.

Thus, among all the four major racial groups in South Africa a decline of fertility has been observed from as early as the 1960s. Figure IV shows that the swiftest decline occurred among the coloureds, followed by Africans.

For South Africa as a whole, fertility was high and stable between 1950 and 1970, estimated at an average of 6 to 7 children per woman. It dropped to an average of 4 to 5 children per woman in the period 1980 to 1995 (United Nations, 95). The current total fertility rate of South Africa stands at 2,9 (SADHS, 1999).

Whites experienced a long and sustained fertility decline from the end of the 19th century until attaining below-replacement fertility by 1989, with a TFR of 1,9 (Chimere-Dan, O, 1993). Asian fertility also declined steadily, from a TFR of about 6 in the 1950s to 2,7 in the late 1980s. Coloured fertility declined remarkably rapidly from 6,5 in the late 1960s to about 3 by the late 1980s. African fertility is estimated to have decreased from a high of 6,8 to a low of about 3,9 between the mid-1950s and the early 1990s. Although it continues declining, African fertility is still substantially higher than that of the other racial groups.

1. Reasons for fertility decline?

However despite this dramatic decline in fertility the majority of African population, especially women still lives in poverty. The question that we, however, need to ask is, "How did this fertility transition come about"?

a) South African past Population policies

This question will be answered by investigating the government's past population policies. The government began to provide strong support for family planning in the 1960s. This support was driven by the fear that rapid population growth would undermine South African prosperity and economic development, but also by concern among white political leaders and administrators that the fast growing African population would overwhelm the much smaller number of whites. As early as 1963, the apartheid government provided substantial funding for private and public family planning services and furnished free contraceptives. In 1974, the South African government launched the well-funded National Family Planning Programme.

The results were impressive and unprecedented in sub-Saharan Africa. By 1983, over half the eligible women in the country were practicing contraception. Despite the aim to lower the African population the government at the same time was encouraging an increase in the white population through immigration.

The programme consequently came under much pressure, both for its ideological focus and the inadequacy of its services. By mid-1980s the programme's management had distanced itself from the demographic intent of the Population Development Programme (PDP). Instead, it promoted the programme's health benefits and started to integrate family planning into other primary health care services.

The introduction of the Population and Development Programme (PDP) in 1984 aimed explicitly at lowering the national population growth rate because the country's resources (especially water) would not sustain the prevailing high rate of population growth. Ironically, the African population was either being denied access to well water-resourced arable land, or being removed and relocated to poor water-resourced land. Thus the minority population owned, or was systematically taking ownership of most of the well water-resourced land in the country. The PDP included interventions in other areas that have an impact on fertility levels, namely education, primary health care, economic development, human resource development, and housing. However, it did nothing to uplift the African population economically nor did it address women empowerment among the African and females.

It must also be said, while it fell short of its original objectives, the programme substantially expanded family planning services. By the end of the decade about 61.2 percent of women ages 15-49 (including about half African married women) were using some form of contraceptive (see figure V).

Thus ironically, while South Africa's family planning program was conceived and implemented by a minority white government intent on slowing the growth of the majority African population and the African communities resisted this approach. It must, however, be made clear that many African women adopted family planning despite the political agenda of the programme.

Most of these women were the only breadwinners and in this sense they were forced to adopt contraceptives. This can be seen in the context that African women assumed management of their fertility because they found themselves increasingly in precarious circumstances. Many factors - cultural, political and social - converged to deprive African women of financial and familial security. These circumstances compelled them to curtail childbearing and to practice family planning, with or without the consent of their husbands or partners. The high use of contraceptive injection indicates that many women are not free to discuss reproductive issues, including contraceptive use, with their husbands or partners. This suggests that the reproductive rights of majority of South African women are still under siege.

Furthermore, many rural African women were without husbands for long periods, since the latter served as migrant labourers in cities. Their prolonged absence left the women to fend for themselves and their children. Many of these migrant husbands simply stopped sending money home or earned too little to be able to afford doing so. This, together with the landlessness and joblessness of the homeland system, forced many African women to make their own decisions about family maintenance and reproduction. The modern family planning programme introduced by the white apartheid regime in the early seventies, assured that their need for fertility control was met.

b) Non-marital fertility in South Africa

Marriage and contraceptive use are two of the most powerful determinants of fertility. In most populations, fertility is directly related to marriage; married women generally have more children than unmarried women of the same age. Traditionally, births to unmarried women were not accepted in most societies, thus women began bearing children after marriage and continued throughout her reproductive lifetime as long as they remained married. In Africa, marriage used to be almost universal and marital fertility was high while non-marital fertility was very low.

In the South African context, marriage seems to have lost its value as determinant of fertility. This can be seen, firstly, from the small and insignificant difference between marital and non-marital fertility of African women in South Africa: in 1996, the average TFR for African women who were never married or who were cohabiting was 3,9, while that of those who were married was 4,3 (Chimere-Dan, 1999). Secondly, it can be seen from the high rate of teenage pregnancies, mainly to unmarried girls.

Although there is a general decline in fertility, teenage pregnancies are still a major concern as illustrated by table 1. The 1998 SADHS found that 35 per cent of all teenagers had been pregnant or had a child by the age of 19 years. This represents a very high level of teenage fertility and is a serious source of concern to the government, communities and researchers. Teenage pregnancies are more prevalent among coloured and African girls particularly those with little or no education. The proportion of teenage girls who had experienced a pregnancy grew from 2,4 per cent to 35,1 per cent with each additional year of age, as shown in the third column of table 1.

The high rate of teenage pregnancies has far reaching consequences, especially for the Africans and coloureds that are the poorest and most disadvantaged groups in the country. The majority of these pregnancies are neither planned nor wanted. The father of the child seldom acknowledges or takes responsibility for the financial, emotional and practical support of the child. The mother often leaves school, thus ending her opportunities for personal development, making her vulnerable to poverty, exploitative sexual relationships and violence as well as low self-esteem.

On the other hand, getting pregnant in African communities does not necessarily mean a loss of educational opportunities. When a school-going girl falls pregnant, she may be forced to leave school, but often only for the rest of the academic year. So high a value is placed on schooling and post-school training, that pregnancy is not allowed to jeopardize it. Teenage pregnancies among Africans and coloureds do not seem to be perceived in the same negative light as in the case of whites and Asians. In most cases the girl does not even marry the father of her first child. Both African women and men value fertility in the African community very highly. It is thus not surprising that, even for unmarried women and teenage girls, pregnancy has a positive value not generally experienced in white communities (Preston-White and others, 1990).

Nevertheless, teenage pregnancies remain one of our major population concerns, which affect mostly communities in the Western Cape, Gauteng and Kwazulu-Natal. This is a challenge to be addressed in a constructive manner, especially in light of the HIV/AIDS pandemic as well as the fact that the human rights of many teenage girls are infringed through acts of sexual abuse and rape.

It has been argued that a higher fertility rate among unmarried and single mothers is a rational response on the part of women, especially Africans and coloureds, to oppressive and disempowering patriarchal economic, social and cultural systems. Among Africans and to some extent coloureds, marriage is far from being an early and universal social institution. African women have consistently low marriage prevalence at all ages. High levels of male migration from rural to urban mining areas have affected lower marriage rates among Africans. Nevertheless, childbearing is almost universal amongst African women. As a result, female-headed households are a common feature in disadvantaged rural and urban fringe areas. Women's burden of carrying the sole responsibility for these children is awesome. The negative implications of this situation manifest themselves as unwanted pregnancies, abortions, abandoned and street children, child neglect and abuse.

A dominant issue in especially the African fertility pattern in South Africa is that of male responsibility in reproductive decision making and health as well as in childbearing and rearing. Women have to take on the burden of caring for children and often also of earning the means to do so. This situation initially arose because of the migrant labour system in South Africa; it was entrenched by the

creation of homelands without viable economic bases and influx control into cities and “white” areas. Men had to go away to work and earn money; women stayed home in rural areas where they had to care for children. Often, the absent fathers stopped sending money home and women had to take on the role of childrearing without the fathers’ support. This situation eventually prevailed also in the African townships outside of the homelands, with women taking the main or even exclusive responsibility for children.

Marriage appears to have lost its role as the exclusive domain for socially legitimate childbearing in South Africa. Overall non-marital fertility has been declining more than its marital counterpart in South Africa both on the national level and across the major population groups in the country (Mencarani, 1999). This intensive control of non-marital fertility appears to be the dominant force in the fertility transition in South Africa. The decline in non-marital total fertility is more likely to be driven by contraceptive use. In addition, as the HIV/AIDS situation in South Africa worsens, the downward trend of fertility can be expected to continue at a much faster pace. The impact of HIV/AIDS on fertility is expected to be threefold: as more women die young before completion of their reproductive years, total fertility will decline; AIDS reduces fecundity of women who would otherwise have borne more children, and increased condom use as a result of public education about the prevention of HIV infection may further boost contraceptive use.

c) Contraceptive use

Because of South Africa’s past history of widely accessible family planning services and health services that are well established relative to the situation in the rest of sub-Saharan Africa, the low fertility rate can also be explained by the high use of contraception. The SADHS found almost universal knowledge of at least one contraceptive method. Three-quarters of all women interviewed indicated that they had used a contraceptive method at some stage during their lives, while 61 per cent of sexually active women reported that they were currently using contraception - see figure V. The national average level of current contraceptive use is higher in urban areas at 66 per cent than in rural areas at 52,7 per cent.

Of the different methods used by sexually active women, 30 per cent comprise injectable contraceptives, 13 per cent the pill and 12 per cent female sterilisation. Condom use is a low 2.3 per cent (SADHS, 1999). The very low prevalence of traditional methods (0,7 per cent) is highly significant, as modern methods of contraception are more effective in preventing pregnancy. At 98,8 per cent of all current contraceptive usage, the use of modern methods is very high compared to that in other sub-Saharan countries. This high use of modern contraception indicates that South African women generally have good access to family planning services and that they generally trust modern contraceptive methods to achieve their goals of either spacing or limiting the number of children they intend to have.

The comparison of contraceptive use by racial group depicted in figure V shows clearly that there was a definite increase in contraceptive prevalence amongst all groups except the white population, which, at about 80 per cent, had in any case reached saturation level.

Contraceptive preference has changed dramatically: some women are more likely to use contraceptives than others and the type of contraceptives used differ. Contraceptive usage is very high amongst urban women, including urban African women – see table 2, and women with higher levels of education – see table 3.

Choice of contraceptive method in South Africa follows racial stratification. Whites, who make the least use of public family planning services, choose from a wider range of contraceptive methods. Africans and coloureds, which constitute the bulk of clients of organised public family planning services, tend to predominately use the contraceptive injection (35 per cent and 27 per cent respectively). This

raises questions about information sharing and the widening of reproductive choices, as well as the issue of women's control over their own bodies and their sexuality.

As illustrated in figure IV, African fertility declined from 6,6 in 1960 to 3,1 in 1998. This is exceptionally low compared to other sub-Saharan African countries. This can be seen in the context that African women assumed management of their fertility because they found themselves increasingly in precarious circumstances. Many factors - cultural, political and social - converged to deprive African women of financial and familial security. These circumstances compelled them to curtail childbearing and to practice family planning, with or without the consent of their husbands or partners. The high use of contraceptive injection indicates that many women are not free to discuss reproductive issues, including contraceptive use, with their husbands or partners.

However, fertility control is far from ideal in South Africa, as evidenced by the fact that about 50 per cent of currently married women have an unmet need for family planning. Unmet need for family planning is inversely related to level of education: the percentage of women with no formal education who have an unmet need for family planning is six times higher than the percentage of women at the highest level of education who show such a need (Du Plessis, 1999). This further emphasises the fact that the majority of South African women have not yet achieved satisfactory control over their reproduction. Addressing the unmet need for family planning entails not merely greater access to contraceptive services, but also the enhancement of the status of women through education and employment as well as changes in social structures that influence female autonomy.

d) Birth spacing and abortion

Younger South Africa women prefer spacing their children, as compared to older women, who prefer limiting the number of births (Du Plessis, 1996). The general trend by age reveals that younger African, coloured and white women tend to view all their pregnancies as too closely spaced, while older women feel that only some of their births are closely spaced. This indicates the extent to which unplanned and mistimed pregnancies occur among young women in South Africa. The gap between stated fertility preferences and observed fertility levels further illustrate the constraints on women's autonomy in decision-making regarding reproduction. In this regard, the SADHS revealed that in most cases the ideal number of children a woman wanted was lower than the living number of children she actually had. Again this suggests that there is a fair amount of unwanted childbearing amongst South African women.

Abortion was legalised in South Africa on socio-economic grounds in 1996. Before the introduction of legal abortion, the termination of unwanted pregnancies often led to increased risk of death and complications arising from unsafe abortions. Although abortion is now legal, there are still moral and religious barriers in some sectors of our society that deter women from practicing this right. The greatest need for access to legal abortion services exists among disadvantaged women.

With the increase in prevalence of HIV-infected women and the risks that the continuation of their pregnancies hold for themselves and their children, the number of women seeking abortion could increase considerably. At this stage it is unclear what effect legalised abortion will have on the total fertility rate, although literature in this regard suggests that, in countries where legal abortions are common, low fertility is generally associated with a high combined prevalence of abortion and contraceptive use. (Rossouw and Du Plessis, 1999).

C. POLICY AND INTERVENTIONS

1. *The South African Population Policy*

The South African Population Policy that was adopted by the 1994 democratic government has shifted from family planning methods. It places population within the development paradigm, which was advocated by the ICPD in 1994. The focus is to fully integrate population concerns into all development strategies, planning, decision making and resource allocation, with the goal of meeting the needs and improving the quality of life of the present and future generations.

Focus is especially placed on the status of women, specifically African and rural women, adolescent reproductive health and questions around poverty. The aim is to address these problems in an integrated manner.

The major thrust of the policy therefore is to ensure that birth, deaths and migration factors are taken into account with all planning. As such a survey for policy implementation was conducted during 2000. The results of the survey shows that most government departments supported the strategies proposed in the policy and that there is a shift in policy planning. A programme to strengthen population development system in government has been developed. This programme is a joint effort between Social Development, Statistics South Africa, (Government Communications Information System (GCIS) and United Nations Population Fund (UNFPA).

2. *Flagship programme for women and children under five*

The Department of Social Development is concerned with the intersecting needs of women and children. In order to demonstrate its move to new priorities in developmental social welfare, a Flagship Programme entitled "Developmental Programmes for Unemployed Women with Children Under Five Years" has been launch. The idea is to develop and/or support developmental programmes that create self-reliance. Objectives include building women's capacity for economic independence and empowerment, as well as providing developmentally appropriate education for children aged 0-5 years old. Funding was made available for pilot programmes within each of the nine provinces and 1448 women participated. In seven provinces the programme reached 1 323 children. The Flagship programme has also provided access to early childhood development (ECD) opportunities. The children are both placed in existing ECD centre or some of the women have been trained and they care for children at the project site.

Thus the main aim of the Flagship Programme is to reduce poverty through providing income-generating activities to women. The specific objectives are: to promote human capacity, ensure self-reliance and well-being among its target population, develop and support unemployed women and their children under five years and facilitate economic, educational and training opportunities for women and their children so that they can provide for the basic needs of their families, thereby breaking the cycle of vulnerability and poverty as well as dependence on the state.

3. *Reproductive Health*

(a) National Adolescent Friendly Clinic Initiative (NAFCI)

The NAFCI is a five-year project started in September 1999 and expected to be completed in 2004. It is led by the Reproductive Health Research Unit (RHRU) of the University of the Witwatersrand, which is based at the Chris Hani/Baragwanath Hospital. The project is a comprehensive service performance and quality improvement accreditation programme. Its initiatives include :

- ❑ expanding access to youth-friendly health services including HIV and STD prevention, reproductive health information to young people,
- ❑ HIV/AIDS testing and counselling, and
- ❑ Provision of care and support services

As an integral component of Love Life, NAFCI will contribute to Love Life's goal to effect positive behaviour change among young South Africans to reduce teenage pregnancy, sexually transmitted diseases and HIV/AIDS.

The main objective is to contribute to making health care facilities more accessible and acceptable to adolescents.

It also aims:

- ◆ To promote a holistic approach to the management of adolescent health needs by health care providers,
- ◆ To set national norms and standards for adolescent health care in clinics throughout the country, and
- ◆ To promote an appropriate clinic environment for the provision of adolescent health services.

4. Water management

South Africa's experiences and lessons learned in implementing population, environment and development policies has demonstrated that community based initiatives, which resonate with people's basic needs, can make a huge difference among poor communities. A community-based environmental and reproductive health programme in two rural districts was initiated in 1998 by the government, together with UNFPA, the Planned Parenthood Association of South Africa and the Working for Water Programme. What is notable about the programme is the overt linkage of population interventions to an environment and development programme with beneficial effects to the communities through the provision of clean water, job creation and promotion of reproductive health information and services, including HIV/AIDS. The project, which was undertaken to restore original water flows to rivers and streams, created many jobs, especially for women, and then became linked to the provision of project based reproductive health services.

5. Food Security

The Department of Health initiated the Integrated Nutritional Programme (INP) in 1995 to address and prevent malnutrition. A process of assessment, analysis and action (Triple A Cycle) is followed to assess the situation, analyse the causes of the problem and to implement services and interventions to address the problem. The mix of services and interventions depends on the findings of the assessment and analysis as well as the availability of resources. It usually combines direct and indirect nutrition interventions and includes service delivery as well as behaviour change aspects.

Examples of direct nutrition interventions include nutrition education and promotion; micronutrient supplementation; food fortification; and disease-specific nutrition counselling and support. Indirect nutrition interventions could include parasite control; steps to improve access to food; provision of health care services; and provision of clean safe water.

The Department of Health operates at national level with a Directorate for Nutrition and provincial level with 9 Sub-directorates/divisions. Structures for managing the INP at regional, district and community levels also exist and are supported by various task teams, and committees.

To effectively reduce malnutrition it is important to collaborate with sectors within the health department as well as other departments. The INP cooperates with a number of sectors which include the Departments of Education, Agriculture, Welfare and Public works; universities and technikons; research institutions; NGO's, CBO's, community project committees; professional associations, consumer organisations, industry and international agencies.

6. Integrated Plan of Children Affected and Infected with AIDS

This is a joint project of the depts of Health, Social Development, Education and Agriculture. The aim is to make interventions around HIV/AIDS. The programme has four components namely:

Life Skills
Home Community Based Care and Support
Voluntary Counselling and testing
Community Outreach

Although the focus states only children it actually focuses on the most vulnerable sectors of society namely women, children and the aged. Life skills are focussing on sexuality in education as well as out of school youth.

7. National Youth Commission

This programme is aimed at involving youth in the reconstruction and development of our country. Services of young people are employed in order to educate other young people about dangers of unprotected sex. A sub-programme the Young Positive Living Ambassadors is an HIV/AIDS programme aimed at employing the services of young people to educate other young people about the danger of unprotected sex, especially HIV/AIDS.

D. CONCLUSION

The South African experience in fertility transition has been unique in sub-Saharan Africa, if not the world. Fertility has declined substantially during the apartheid era to a TFR of 2,9, which is unprecedented relative to the rest of Africa. The transition towards closing the gap between low fertility aspirations and small completed family sizes has moved much further in South Africa compared to the rest of sub-Saharan Africa. However, this occurred amidst great social upheaval of especially Africans, the impoverishment of millions, a large proportion of who were African women and their children, stark inequalities and the systematic disempowerment of women.

An attempt was made to explain the reasons for this dramatic fertility decline despite high levels of poverty and low levels of development among all four racial groups. The issues of high non-marital fertility in South Africa and high contraceptive use were discussed in order to better understand the singular manifestation of fertility decline in conditions of low status of women and abject poverty. We found evidence that various factors converged to create the situation where women had to accept virtually sole responsibility for childrearing without access to productive resources. Their response was to control their fertility, not as a result of educational and career aspirations or affluent lifestyles, but as a survival strategy. The reproductive and sexual rights of South Africa's disadvantaged women were constantly disregarded and abused on the one hand, because of the total breakdown in family life caused by influx control and the homeland system, and their low status and lack of development on the other hand. Nevertheless, they accepted contraception as their way of exercising some control over their own bodies.

The basic difference between fertility patterns in South Africa and the rest of sub-Saharan Africa is not based on fertility being valued differently; fertility is still highly valued in South Africa. Rather, it was deprivation of access to land and the total breakdown of the traditional lifestyle, both socially and economically, that made fertility control a rational choice for South African women.

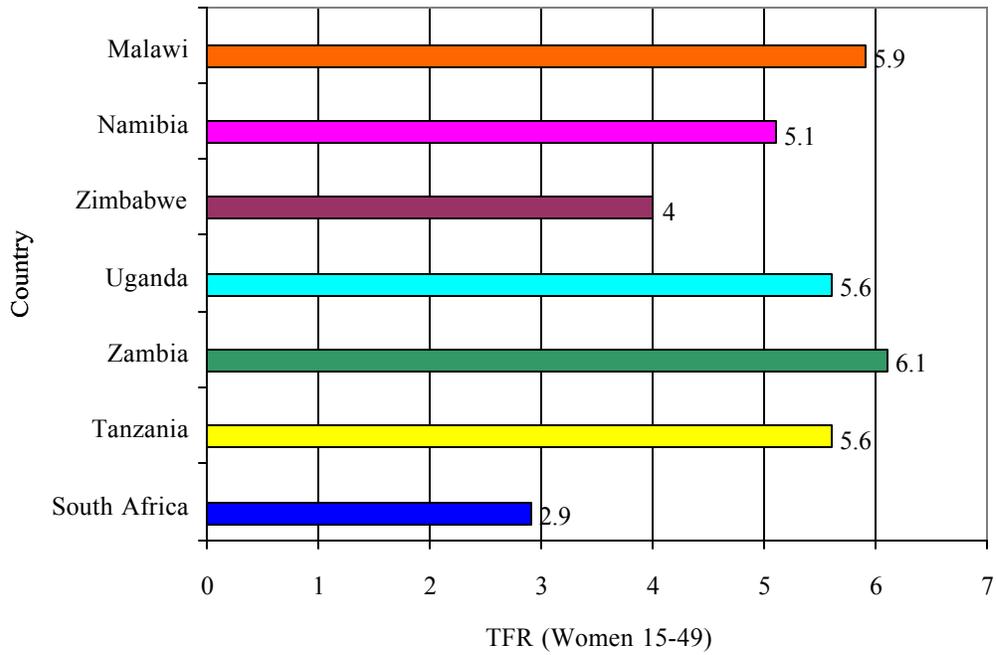
However, the high levels of unwanted and teenage pregnancies as well as the high unmet need for contraception are still of major concern. This shows clearly that women, especially Africans and coloureds, still lack control over their own reproductive choices and still experience emotional trauma with respect to fertility. They further lack the development opportunities to empower themselves in order to take full control over their reproductive lives, as propagated by the International Conference on Population and Development in Cairo, 1994. HIV/AIDS and its consequences will definitely lower the fertility rate in the near future and its full impact is still not clear.

While poverty, racial and gender inequality and fragmentation of society persist, we cannot pride ourselves as South Africans on our excellent gains in fertility decline. As long as South African women do not enjoy freedom to control their own bodies within supportive relationships with husbands or partners, population problems relating to fertility will remain a major national concern.

Specific focus needs to be put on empowerment programmes for teenagers as well as vulnerable African rural women in order for them to take control of their reproductive choices. The lack of male responsibility for childrearing that was emphasised as a crucial contributing factor to African women's need for fertility control holds significant implications for reproductive health programmes and services. Essential interventions include the upliftment of the status of women through education and employment, radical changes in the social structures that influence female autonomy and the eradication of poverty.

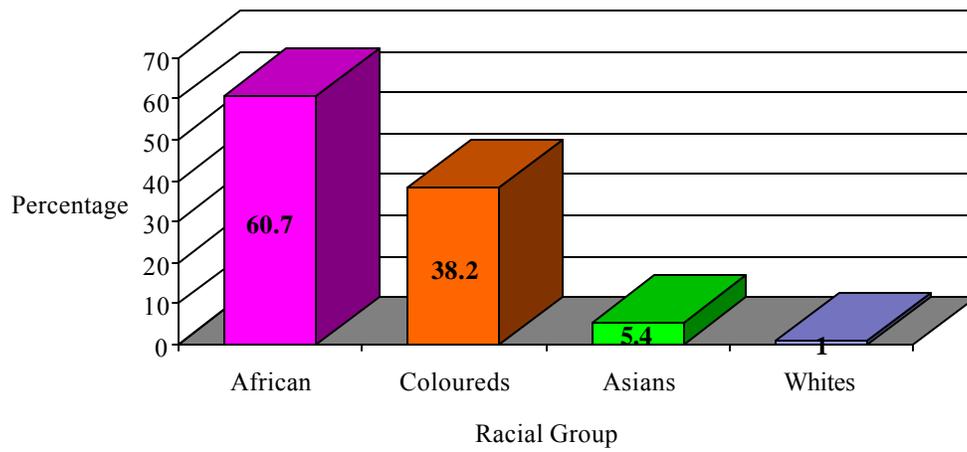
It is the author's believe that fertility will kept on declining for the African, Asian and Coloured populations and will reach replacement level by 2020-2025. However, with the future impact of HIV/AIDS on our population growth replacement level could even be obtain at a much earlier date as anticipated.

Figure I. Comparative levels of fertility in Southern and East Africa



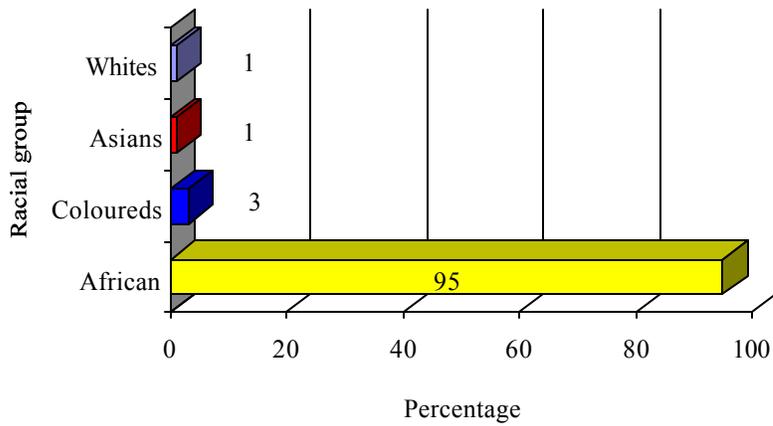
Source: Population Reference Bureau, World Population Data Sheet, 2000 (Washington: PRB, 2000).

Figure II. Poverty Rates among population groups



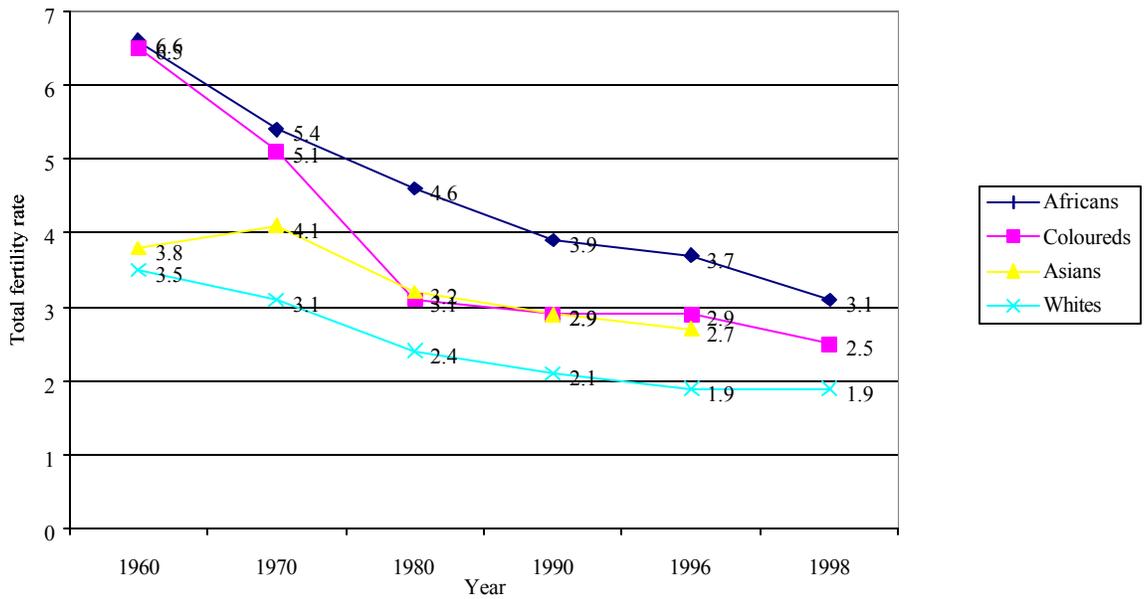
Source: Poverty and Inequality in South Africa (PISA). Fishwicks, Durban. 1998.

Figure III. Poverty Gap



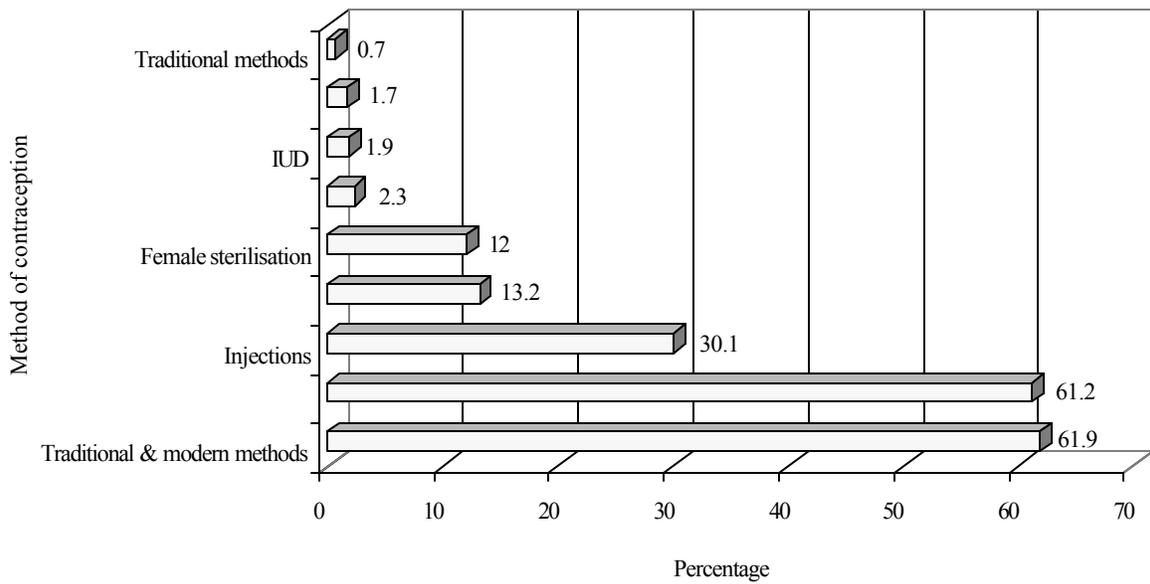
Source: Poverty and Inequality in South Africa (PISA). Fishwicks, Durban. 1998.

Figure IV. Differentials in total fertility rate by race, South Africa, 1960-1998



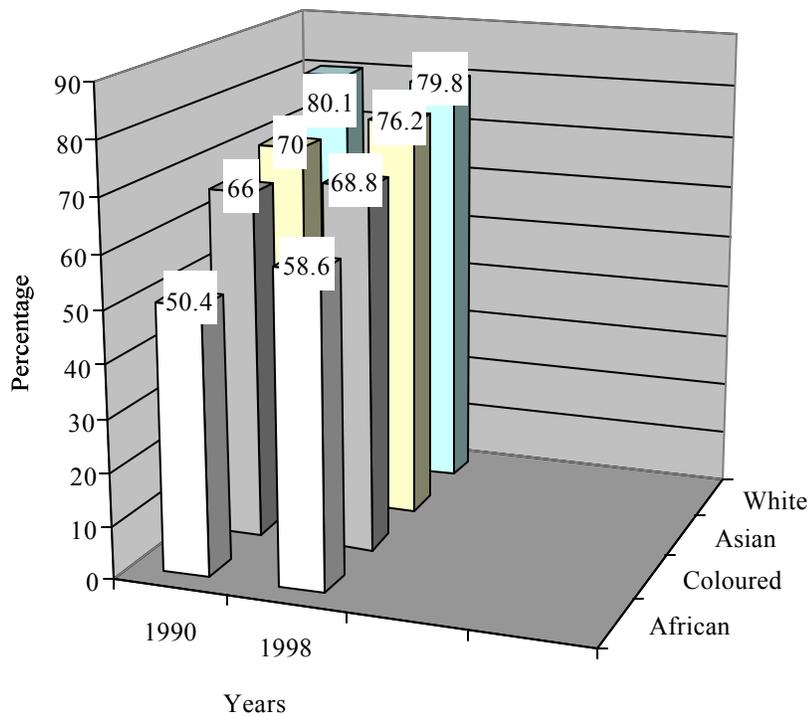
Source: Report of the Science Committee of the President's Council on demographic trends in South Africa (Pretoria, Government Printers, 1983)., SADHS Project Team, "South Africa in transition: selected findings from the South African Demographic and Health Survey" (Pretoria, Government Printers, 1998) and Population Reference Bureau, World Population Data Sheet, 1998 (Washington: PRB, 1998).

Figure V. Current contraceptive use in sexually active women



Source: SADHS Project Team, "South Africa in transition: selected findings from the South African Demographic and Health Survey" (Pretoria, Government Printers, 1998).

Figure VI. Comparison of contraceptive use by racial group between 1990- 1998



Source: SADHS Project Team, "South Africa in transition: selected findings from the South African Demographic Health Survey" (Pretoria: Government Printers, 1998).

TABLE 1. TEENAGE PREGNANCY AND MOTHERHOOD (PERCENTAGE OF WOMEN AGED 15 TO 19 WHO ARE MOTHERS OR WHO HAVE BEEN PREGNANT BY BACKGROUND CHARACTERISTICS, SOUTH AFRICA 1998)

<i>Background Characteristics</i>	<i>Percentage who are</i>	
	<i>Mothers</i>	<i>Ever pregnant</i>
Age		
15.....	2,0	2,4
16.....	5,2	7,9
17.....	10,7	14,2
18.....	19,8	24,6
19.....	30,2	35,1
Residence		
Urban.....	10,5	12,5
Rural.....	16,3	20,9
Race		
African.....	14,2	17,8
African urban.....	11,6	13,7
African: non-urban.....	16,4	21,1
Coloured.....	15,7	19,3
White.....	2,2	2,2
Asian.....	2,9	4,3
Total.....	13,2	16,4

Source: SADHS Project Team, “ South Africa in transition: selected findings from the South African Demographic and Health Survey” (Pretoria, Government Printers, 1998).

TABLE 2. CONTRACEPTIVE USE BY RESIDENCE, SOUTH AFRICA 1998

<i>Residence</i>	<i>All modern methods (%)</i>
Urban.....	66,0
Rural.....	52,7
Total.....	61,2

Source: SADHS Project Team, “ South Africa in transition: selected findings from the South African Demographic and Health Survey” (Pretoria, Government Printers, 1998).

TABLE 3. CONTRACEPTIVE USE BY LEVEL OF EDUCATION, SOUTH AFRICA 1998

<i>Level of education</i>	<i>All modern methods (%)</i>
No education.....	33,1
Grades 1 to 5.....	43,7
Grades 6 to 7.....	53,6
Grades 8 to 11.....	64,6
Grade 12.....	73,1
Higher.....	78,1
Total.....	61,2

Source: SADHS Project Team, "South Africa in transition: selected findings from the South African Demographic and Health Survey" (Pretoria, Government Printers, 1998).

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